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District Nursing

CONTENTS

Editorial

A NEW attitude towards mental health is needed in this country: a positive attitude which will help promote positive mental health as well as treating mental ill health. The Mental Health Act 1959 increases the responsibilities of local authorities and provides the legislation necessary to enable mentally ill patients to be treated in their own homes, or in the same hospitals as those suffering from physical illness, thus removing the stigma of the mental hospital.

Dr. R. F. Tredgold, in his address to a conference on this subject (see page 228) commented that the Act was really a mental illness act, and felt we should not deceive ourselves by using the word health when we meant illness. Nevertheless, the dividing line between the two is so indeterminate that, at least from the layman's point of view, they are probably best considered together.

It is the outlook of the general public that health visitors and district nurses can greatly influence. In fact education of the public can be one of their most important contributions to positive mental health. Even in these days many, who pride themselves on being "broadminded", regard mental illness as a stigma, instead of a disease, unfortunate but no more disgraceful than physical illness. The provisions of the 1959 Act for training mental defectives to live as members of the community, and for treating the mentally ill in the community, will be of no avail if the members of that community are not sympathetic and ready to help.

The new Act is also a challenge to district nurses and health visitors to make full use of their training in observation. The observant nurse will often recognise signs of incipient mental illness during the course of a visit to another member of the family. She can diagnose mental illness before the patient or relatives are aware of anything wrong. By looking and watching carefully, she will notice the early signs of strain; even apparently unimportant changes such as sudden extreme untidiness in a normally tidy person. By listening sympathetically, she can help a patient help himself by talking out loud, clarifying things in his own mind, and even talking the trouble out of his system.

1960 is World Mental Health Year. Its aim is to focus attention on the efforts towards positive mental health which are being made in the forty-one member countries of the World Federation for Mental Health, and to promote and plan a long-range programme. For although 1960 is the year of major effort, it is intended that the work shall continue for a considerable time.

This therefore is an appropriate moment for those concerned with the health of this country to start on their contribution toward positive mental health.

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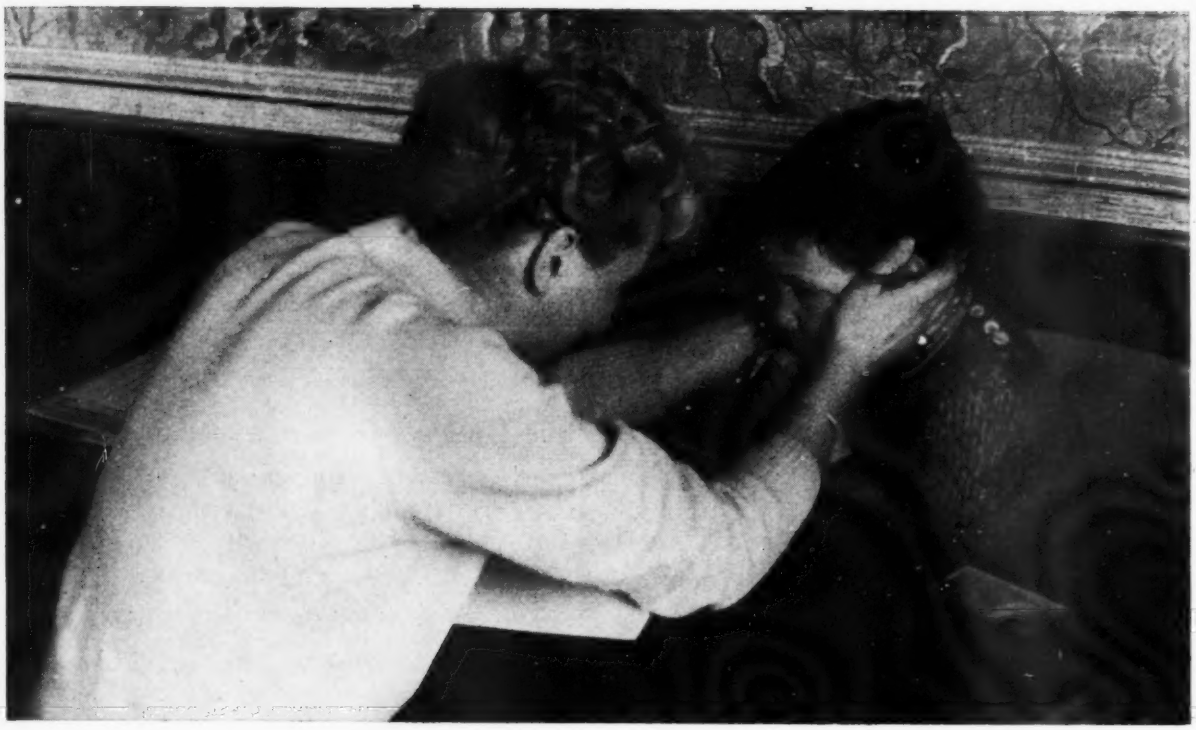


La Demoiselle des Nerfs amongst the Mountains

by JEAN MOHR

IN the heart of prosperous Switzerland lies the mountainous state of Valais, whose people are reserved and self-contained, and where life is often hard and communications difficult. There, for thirty years, under the stimulation of Dr. André Repond, a member of the WHO Expert Panel on Mental Health, an experiment has been carried on which today is an example to all under-developed countries that are establishing mental health services.

Dr. Repond and his associate, Dr. N. Beno, have been the moving spirits in the school medical service engaged in case-finding and treatment of mental disorders in children. Psychologists, psychotherapists and psychiatric social workers regularly visit the most remote villages of this mountain country to examine children with nervous d sorders such as enuresis, stuttering and tics, with psychosomatic illnesses, and with character problems of the order of shyness, aggressiveness and temper tantrums.

The suspicion that they met everywhere thirty years ago has disappeared almost entirely. The religious and civil authorities—teachers, mayors, policemen and judges—now help them, so that Dr. Repond's and Dr. Beno's assistants are cheerfully greeted everywhere as "les demoiselles des nerfs".

left:

At School, "*la demoiselle des nerfs*" *examines the children whose marks are low. Are they children of limited ability or of normal intelligence? Why do they lack interest in their studies? Is it psychological? Home conditions?*

At Home: "*La demoiselle des nerfs*" *concerns herself with children who are obsessed by nocturnal fears, who are guilty of petty thieving, who do not mix with other children, or who play truant. Parents who are often misguided in spite of their good intentions are taught to follow the advice of the psychotherapist in dealing with children.*

right:

Good Children *may be hiding neurotic disturbances. Teachers have great difficulties in spotting mental disorders in obedient pupils. It is recognised that good behaviour in school children is not necessarily a healthy sign. But these look healthy enough!*

From a lecture at a refresher course arranged by East Sussex C.N.A.

Personality Factors in Health and Illness

by J. T. ROBINSON, O.B.E., M.A., M.D., D.P.M., D.T.M. & H.
Medical Director, Roffey Park Rehabilitation Centre

PERSONALITY is what distinguishes one person from another. Each individual has a characteristic way of perceiving, feeling and behaving. Habitual behaviour is the essence of what we understand by personality and is derived from the inter-action between an individual and his environment.

It is the integration of constitutional (physical), cognitive (intellectual) and conative (instinctual) factors or, more simply, the integration of the physical, intellectual and emotional factors and their development.

Heredity provides the framework on which the final personality is formed. The factors bestowed upon each individual by birth are constitution, intelligence and certain biological urges which require satisfaction: food, drink, rest, activity, curiosity, sex, aggression and self-assertion. It is upon these basic driving forces that we depend for energy to make a success in life. In addition there are emotional capacities, for example, to experience positive feelings: love, pleasure and amusement; and negative feelings: hate, rage and fear. Since endowments vary, each individual is potentially more or less sensitive or, to put it in another way, is endowed to meet successfully or avoid the hurts he will have to face in life.

While heredity factors are important since they form the structure upon which the final personality is shaped, it is the environmental influences, particularly in childhood and adolescence, that determine whether the personality will become stable or otherwise. In other words, whether it can cope with stressful situations or whether it is vulnerable to stress. These influences are those of home, school, education, social contacts and illness.

Early Influences

It is not my purpose to go into the details of all these influences, but I want to emphasise certain facts regarding the influences in early life, particularly that of the family, namely the parents or parent substitutes, since these have probably the greatest effect in moulding the character structure or personality. The importance of parental influence becomes evident when it is realised that personality formation starts when the child is introduced into the world and when for the first time it meets more than one person, i.e. the father and the mother.

The new-born infant is virtually helpless and depends on the mother for the satisfaction of all his needs. These needs are essentially instinctual or biological. When he is hungry or uncomfortable (from whatever cause) his immediate reaction is to cry. This cry serves the purpose of bringing the mother to the child and having her relieve the child's discomfort, unhappiness and tension. The child quickly comes to recognise that the mother is the one who relieves his distress and so long as she is present he knows that he is safe and he does not feel helpless. If the mother is sufficiently available the child soon develops a feeling of security and thus develops gradually the capacity to tolerate some discomfort distress or tension before requiring its relief, knowing that the mother will come.

If, on the other hand, the mother is deficient in her care of the child and indifferent to his biological and instinctual needs, the child cannot depend on her to bring relief and comfort and this engenders a feeling of insecurity and tension in the child. This effect can be seen later in the obviously frightened child clinging to the mother's skirts and in the emotionally disturbed state of the child when the mother goes away, despite reassurances of her return.

There are certain well-recognised stages in the emotional and sexual development of every child and there is a close relationship between biological needs (instinctual drives) and mental stability. These stages are those of breast feeding, weaning, bowel and bladder training, followed by a stage in which interests and drives are directed to doing things with those of the same sex; boys become Indians and interested in aggressive pursuits, and exclude girls; girls play games with dolls and imitate mother and mother-figures, to the exclusion of boys. Gradually interests in the opposite sex are aroused and become more evident around puberty and adolescence.

Maturation of the personality depends on the satisfaction or frustration experienced during each and every stage of this development. These change as the child matures and leave their effect on the personality.

The new-born baby derives the greatest pleasure from contact with the mother and therefore from sucking and swallowing. Later, as a consequence of development and growing up, frustration is experienced associated with weaning. Pleasure in sucking and swallowing gives place to pleasure in biting and still later in vocalising and speech. Similarly, pleasure and frustration are associated with bowel and bladder training, use of aggression and curiosity and in genital development.

As the child grows older, he is called upon to assume more responsibility himself and to modify his primitive instinctual behaviour to meet the demands of his society

and the culture into which he is born. He is taught to control his sphincter, so that he evacuates his bladder and bowels in acceptable places; to eat his food properly and to keep his primitive aggression (temper) under control; to limit his curiosity and in general to behave as a cultured, civilised human being.

These demands of the parents are complied with because the child wants to please his parents, to retain their love and to avoid punishment.

As the child develops, he begins to feel erotic feelings in the area of his own genitals and also great curiosity about the sexual differences of parents and children of the opposite sex and also curiosity about where babies come from. Unfortunately our culture maintains a conspiracy of silence about such interest. The mishandling of this normal curiosity by parents may give undue attention and disgusting significance to the sexual organs and their function. This will produce an attitude which will have serious consequences in later life. Masturbation is a frequent practice in children. I have vivid recollections of tracts and dissertations by various well meaning but misguided adults on the evils of masturbation and the serious consequences therefrom. Many parents and stupid adults leave children with the impression that masturbation will sap their brains or produce some mental or physical disorder; nothing is further from the truth. What this attitude creates in children is a sense of guilt and anxiety, and it is this that has the direct consequences on the personality.

Discipline is necessary in bringing up children. I have little time for those who believe in pandering to every whim of the child and letting him do as he likes, when and where he likes. Such children are never happy, but grow up to expect that they can demand anything from life and that their demands will be met, irrespective of the feelings and needs of others. As adults, should they ever reach that stage, there is a rude awakening for such children which is often severe and shattering. Discipline is an important part of personality development and inevitably implies prohibitions and frustrations to the growing child's needs. But it is how discipline is enforced and exercised that determines the effect for good or evil on character formation. Harsh and inconsiderate dealing with children at any of the major developmental stages will produce fears and uncertainties and have a detrimental effect on mature personality development.

All these influences determine the development of the child into a mature or immature adult; make an individual capable or incapable of meeting with the normal stresses such as disappointments, frustrations, fears, rebuffs, failures and suchlike hurtful experiences which go to make up the vicissitudes of adult living. The mature personality meets them, copes with them and deals with them satisfactorily, but the immature personality is vulnerable and therefore may break down in illness or become a rebel against the social culture into which he is born.

It is evident from what has been said that it is emotional maturity that is of major significance in the development of the child into the adult. Such maturity depends on childhood experiences and influences and the capacity to make realistic compromises between basic desires and instincts and the demands of the environment. Where these compromises are unsatisfactory, immaturity results.

Let us briefly direct our attention to the effects of misguided handling of children through the various stages of development from infancy through the acquirement of assertion and conscience, the effects of family rivalry and the problems of school years and adolescence.

While these stages are dealt with separately to give emphasis to the extreme results, it must be recognised that they are modified by kindlier and happier experiences from relatives, friends and associates throughout the early years of childhood.

Infantile Dependency

As a result of bad mother/child relationship the infant fails to develop adequate security. This is shown later in life in an excess of dependency need (over-dependency) or avoidance of dependency and sometimes permanent anxiety state with fear of social contacts.

In the case of over-dependency the child grows up with excessive residuum of dependent needs, the parasite who preys on the kindness and generosity of others. This may be seen in the married woman of middle age who still thinks of herself as a relatively helpless child in relation to everyone else, from her grown-up children to the doctor who sees her. All her life she seeks for the fulfilment of dependent needs denied her in childhood. Her pattern of life reflects both her dependent needs and the frustrations which have resulted from her vain search for their fulfilment. She clings to her doctor, to her friends and to her husband, an executive who manufactures shoes, but as a sideline manufactures excuses to spend much of his time away from home and from his wife's parasitic dependency.

When her husband is away she spends her time with her mother and sister, describing in minute detail her vague physical symptoms. Long ago she realised she could obtain attention and sympathy and the fulfilment of her dependent needs (at least temporarily) when she was ill. Her symptoms rise or fall with her loneliness and dependent needs. Her children's relationship to her is obligatory, no real affection, and when they married they took pains to find homes as far away as possible. She resented her children from the moment of conception but would deny this with conviction as she has concealed it from herself. She was obliged to be a good mother but found it difficult to give affection since all she was prepared for was to receive it.

Before marriage she was a filing clerk; if everything was set for her and she was told what to do, she did reasonably well, but she could accept no responsibility and avoided opportunity for promotion. Her greedy demanding nature makes her lose friends easily. She seeks refuge in religion but this does not fulfil her needs.

The avoidance of dependency can be illustrated by the adult male who avoids dependency at all costs, takes pride in doing as much as or more than the next man does; he never admits defeat, never permits himself to demand help from others. He wants to run everybody. He takes on other people's problems (often without their express request) but in anything he does he brooks no interference.

In marriage he is all give and no take. He makes all the decisions. He is solicitous for his wife's welfare but when she is ill he gets annoyed, minimises her illness and is impatient if she does not get well at once. He is a poor father, avoids his children and dislikes them when they cry. He wants them to be brave and strong, to settle their own problems and to behave as if they were already adults. At work he is energetic and competent but finds it difficult to delegate authority or to accept supervision. When he is working alone or with compliant subordinates he gets through a tremendous amount of work. He frequently works evenings and weekends and limits his vacation to a few days of strenuous activity interspersed with telephone calls to the office.

He is competitive with his friends, plays golf vigorously on Sundays and is too restless to sit in church. He not only believes that it is more blessed to give than to receive but that it is dangerous to receive. If he is ill he cannot accept his physician's instructions or orders (if couched in authoritarian tones). If he is seriously ill he regresses into dependency and becomes as helpless as the patient previously described. But when he starts to feel better the pattern starts all over again. The fear of abandonment, being hurt and rejected in infancy and later the criticisms and humiliations suffered at parents' hands have conditioned him to stay clear of dependency on anyone.

He should be made to feel that he has a part in deciding the treatment and allowed to talk himself into the necessary treatment.

Assertion

Over-assertion is provoked by mishandling in childhood to anger and hostility. The adult's characteristic is to fly off the handle; he upsets people at work, picks quarrels if provoked. If things go well at work he takes out his frustrations on his wife and children and provokes fear in the family, always wanting his own way. This costs him the love of his family, and therefore increases his resentment. His rebellious nature makes people avoid him. He is a bad loser. When ill he is angry and quarrels with the doctor. This hostility can wreck human relations. Treatment is sublimation in physical work, athletics or business or intellectual competitions.

Under-assertion is seen in the passive, dependent, timid, self-effacing individual, inhibited, kind and meek. The henpecked husband, very easy to get on with, makes many friends who exploit him and who are a little condescending towards him. He submits with apparent docility to his wife's commands when she is at home. When she is away he is always available to do extra jobs to fill in for others, but is not aggressive enough to seize opportunities. He is terrified of authority, placating and submissive.

Even the doctor exploits his passivity; when the doctor's consulting room is full, Mr. X. will understand. As a salesman or in any role where assertion is required, he is a total loss. These timid, shy, asocial individuals often become eccentrics and help to form the group known as the schizoid personality. Should they become mentally ill, they frequently present schizophrenic symptoms.

Conscience

The defective conscience is the result of inconsistent parents. The man has no concern for others; exploits his family. He is unfaithful to his wife and unconcerned about his children. He is work-shy, only doing enough to avoid being caught out, and cheats at games. He never pays debts.

Such individuals swell the ranks of what one recognises as the antisocial or sociopathic personalities. All have the characteristics of living by the pleasure principle and have no consideration for others. What they want they must have by fair means or foul. They are drifters on the sea of life, can never hold a job and are quite immune to punishment. They form the large bulk of the criminal classes and are often guilty of acts of violence against person or property. They are frequently untreatable as they are unwilling or unable to co-operate in any therapeutic regime.

The adult with a rigid conscience is over-conscientious, meticulous in detail, rigid and unyielding with little sense of humour, preoccupied with attaining perfection; he cannot see the wood for the trees. He is unable to express his feelings—cannot enjoy anything. His home is run to rule: he gets angry if meals are late or children break rules. He usually expresses his anger indirectly. He is always in a dilemma in making up his mind about what is right and wrong. His underlying aggression is shown in his eagerness to criticise others and pick out errors. Useless in creative work, or work which involves frequent change, book-keeping, watch repairing and other jobs which require an interest and attention to detail are his goal. Should such an individual become mentally ill he develops obsessional neurosis or severe depression.

Identification

In the normal happy family—and these, I believe, are the majority of families—the boy is usually like the father and the girl like the mother. There is an unconscious imitation of parental characteristics which is called identification. This depends upon which parent exercises the major controlling and disciplining influence on the child.

Sometimes normal identification does not take place, as when the father fails to take his proper role as head of the family. In such a case the kindly mother assumes direction and if her child is a boy he will identify with her. When he grows up, such an adult will get on well with women but may find difficulty in getting on with men.

continued on page 234

A report on the Royal College of Nursing conference: MENTAL HEALTH—TODAY AND TOMORROW, by Margaret B. Nicoll, tutor to the Bolton Health Visitor Course

The Framework for the Future

THE MENTAL HEALTH ACT 1959

THE Act was introduced by **Mr. Derek Walker Smith,** who said that no time had been wasted in the passing of the legislation. There were two main provisions in the Act: (1) as much treatment as possible in the hospital and outside it, on as informal and voluntary a basis as is required for treatment in a general hospital; (2) appropriate provision for patients whose compulsory admission was still necessary in the interest of either the patient or society as a whole.

The background of the Act was one of shifting emphasis from institutional care to community care and the Act aimed at treatment of mental disorders on the same footing as other illnesses. Obstacles to progress were swept away, the out-of-date jettisoned in keeping with medical and social advances.

Any general hospital is now legally empowered to receive patients suffering from any form of mental disorder, and the minister expressed the hope that this would accelerate the setting up of psychiatric units within the general hospital, and also the provision of specialist treatment particularly for the sub-normal and psychopathic patient.

In conclusion, recalling a vivid phrase used by Sir Winston Churchill, the minister said: "This Act must not be a sofa but a springboard; a springboard for further fruitful effort by all those who are working to illuminate the dark corridors of the human mind with reason restored and hope reborn".

Outline of the Act

Before reporting the conference further, it may be useful to outline briefly the provisions of the Mental Health Act 1959. This Act repeals all previous Acts relating to mental illness and mental deficiency: The Lunacy and Mental Treatment Act, 1890–1930; The Mental Deficiency Act, 1930–1938; and the Act which allowed the Board of Control to be constituted.

Part I

1. The Board of Control will be dissolved, and its functions transferred to Ministry of Health and Mental Health Review Tribunals. (There will be one tribunal for each regional hospital board area.)

2. The term *mental disorders* will be used to cover all forms of mental illness and disability.

3. Classification of mental disorders under headings that are defined: mental illness; severe subnormality; psychopathic disorders.

4. Admission to hospital will be on an informal, voluntary basis in the same way as patients are admitted to general hospitals.

Part II

1. Functions of the local authority will be extended under National Health Service Act 1946, National Assistance Act 1948 and Children's Act 1949.

2. Prevention of illness and the care and aftercare of patients will include persons who are or who have been suffering from mental disorders.

Main requirements of the Act are: provision of residential accommodation and care of persons residing there; provision of training centres and other facilities; appointment of mental welfare officers; supervision and care of persons under guardianship; care and training for children who are ineducable because of mental disorders, in residential and other accommodation; compulsory attendance at a training centre of children suffering from mental disorder.

Part III

Registration and inspection of all mental nursing homes and hospitals other than those under regional hospital board or local health authority and of all residential homes for the mentally disordered (Public Health Act 1936; National Assistance Act 1948).

Part IV

Compulsory admission to hospital:

(*a*) *For observation* on the grounds that: (*i*) he is suffering from mental disorder of a nature or a degree which warrants his detention under observation; (*ii*) he ought to be detained in the interests of his own health or safety or to protect other persons. Compulsory detention 28 days unless he is in the meantime re-admitted as the result of an application for treatment.

(*b*) *For treatment* on the grounds that he is suffering from mental disorder: (*i*) in the case of a patient of any age: mental illness or severe subnormality; (*ii*) in the case of a patient under 21 years: psychopathic disorder or subnormality of a nature or a degree which warrants his detention for

SPEAKERS

The Rt. Hon. Derek Walker-Smith, Q.C., M.P., *Minister of Health.*
R. F. Tredgold, M.A., M.D., D.P.M., *physician in the department of psychological medicine, University College Hospital.*
J. P. Horder, M.A., B.M., B.Ch., M.R.C.P., *general practitioner.*
A. Elliott, M.D., D.P.H., *county medical officer and social welfare officer, Kent.*
R. K. Freudenberg, M.D., D.P.M., *physician superintendent, Netherne Hospital, Surrey.*
D. MacMillan, B.Sc., M.D., F.R.C.P.E., D.Psych., *physician superintendent, Mapperley Hospital: medical officer for mental health, Nottingham.*

treatment; (*iii*) necessary in the interests of his health or safety or for the protection of other persons that he should be detained.

Application for admission for observation or treatment may be made by the nearest relative or the mental welfare officer. Relative must agree to treatment.

Admission is based on two medical recommendations. Except where there is emergency, the applicant must have seen the patient within the previous 14 days. In urgent necessity application for admission for observation may be made on one medical recommendation but will cease to have affect after 72 hours unless the remaining requirements are fulfilled.

Mental Health Review Tribunal: patient detained in hospital for treatment may make application six months from the day of admission or on his 16th birthday, whichever is the later.

(*c*) *Reception into guardianship of local authorities or other persons.*

(*i*) Application for guardianship may be made in respect of a person of any age who is suffering from mental illness or severe abnormality or

(*ii*) in the case of a person under the age of 21 years if he is suffering from a psychopathic disorder or subnormality,

on the grounds that the above conditions warrant his reception into guardianship and that it is necessary in the interest of the patient or for the protection of other persons.

Part V

Deals with persons coming before the courts.

Part VI

With the removal of alien patients who are having treatment compulsorily detained outside the United Kingdom.

Part VII

The management of property and affairs of mentally disordered patients.

(*See also page 235*)

THE IMPLICATIONS OF THE ACT

Dr. R. F. Tredgold commented that this new legislation was a wonderful Act, although it was *not* a mental health act but a mental illness act. The title of the Act was misleading as there was a danger of deceiving ourselves by using the word health when we meant illness.

We needed to ask ourselves the following questions: What are the factors which produce health? Do we know what people are like when they are well?

Why is this a good Act? Dr. Tredgold asked. First of all, it is a step forward, putting mental illness on the same footing as other illnesses. It will get rid of wrong attitudes to mental illness, and if we achieve this we shall have done more than our ancestors have done.

Today people are deprived of treatment because of lack of staff. There is only one doctor to every 150 to 200 patients, and if they worked a 70-hour week, they could give only one and a half hours to each patient a year. Expansion of staff is necessary and the cost will be enormous.

This is still only dealing with the sick. We are not yet thinking in terms of health. There is a need to be realistic today so that preparations can be made for tomorrow, for the passing of the Act will not help at once.

More people will seek advice earlier and expect a higher standard of treatment. More doctors and nurses are needed and we must ask ourselves whether there is likely to be an increase and if they are found, whether they can be trained? Otherwise, the sympathy of the public will be lost.

There are additional factors which could help to solve this problem during the period of transition. We should deploy our resources to the best advantage: Dr. Tredgold thought that highly trained staff should not waste time doing unskilled work. We should use what measures we can to save time, e.g., group therapy, and where resources are limited, concentrate on major effort.

We should make use of education in its widest sense, for example through parents, school teachers, radio and television, and use any member able to teach people at any time.

There is opportunity within the nursing profession for moulding other people's views and we should be asking ourselves the following questions: Do doctors and district nurses work on equal terms? Do district nurses need more education in handling psychoneurotic patients, and if so how are they to get this? Do they spend time talking to patients and if so, is this a waste of time, a pleasant break or useful treatment? Do district nurses enjoy the close co-operation of family doctors, medical officers of health, and the hospital out-patient department? Are patients in mental hospitals treated with as much personal attention as those in general hospitals? Are mental nurses the poor relations of the nursing profession? Are they semi-skilled? What skill have they that other nurses have not?

Do we attempt to remove prejudice and fear on and off duty? Do nurses ever go into mental hospitals to see what goes on there? Are nurses who have been patients in mental hospitals accepted back on the staff after recovery? Do they know how emotions affect physical conditions? In nurse and medical education is as much taught about health as about illness?

The morning session was followed by group discussion. Dr. Tredgold's address caused much thought and the many questions he posed made for lively discussions. Points which arose were varied. Some of those put to a panel later on were:

Voluntary secondment of student nurses to psychiatric hospitals.

Comprehensive basic training for all nurses should include a period in the psychiatric hospital and the hospital for mental defectives. Only then could the nurse call herself a *general* trained nurse.

What is being done to change the attitudes of medical and nurse students towards accepting the mentally ill?

Recruitment of doctors and nurses to psychiatry.

Tribunals and the qualifications and suitability of legal, medical and other persons serving on them.

What will be the effect on the future of psychiatric hospitals if there is an expansion of treatment in general hospitals?

Meeting the Needs of the Community

THE PART OF THE GENERAL PRACTITIONER

Dr. Horder said that of every hundred patients with mental disorders who came to the general practitioner, only three or possibly two entered a mental hospital. He thought admission to hospital was an admission of failure. The other 97 per cent of the general practitioners' patients suffering from mental disorders are treated in the community, and this should be so whenever possible.

Out of every hundred patients the general practitioner sees, there will be one psychopathic personality and two suffering from mental disability. The others will be suffering from mental illness. Ten per cent of the latter will see the psychiatrist.

The mental disability of the majority of patients seen in general practice is not severe. The schizophrenic patient is a rarity. Most illnesses are slight and transient. The majority of us become upset from time to time in certain situations, for example, after a week or two of inadequate sleep, and this comes within our definition of mental disorder.

Diagnosis and treatment need the right attitude—"There but for the grace of God go I". Early diagnosis is the most important part which the general practitioner can play. He has to decide whether there is a mental disorder, for as a rule it is a physical problem which is presented.

The general practitioner may treat the patient himself, and if he decides to do so he has a wide choice of help available: the psychiatrist, psychologist, psychiatric social worker, home help, clergy, district nurse, probation officer, health visitor, Alcoholics Anonymous, Meals on Wheels, and many others.

Co-operation with the psychiatrist is important for the general practitioner has a vital role to play in preparing the patient to receive the psychiatrist; explanations are needed by both the patient and the relatives. The health visitor and the general practitioner are natural allies; traditionally they seldom see each other in the city but in the rural areas it is different. Administrative re-organisation is needed so that the health visitor can work with the general practitioner as the almoner works with the doctor in hospital with excellent results.

THE PART OF THE LOCAL AUTHORITY AND THE VOLUNTARY ORGANISATIONS

The 1930 Mental Treatment Act emphasised services within the hospital but the 1959 Mental Health Act laid the emphasis on the services in the community, said **Dr. Elliott.** The National Health Service Act 1946 placed the responsibility for care of the mentally ill on the regional hospital boards and the local health authorities.

Medical and nursing care is the responsibility of the regional hospital boards and where hospital resources are not needed the responsibility for the provision of residential accommodation and the care of people requiring this falls on the local health authority. There are too few workers for this work and in-service training is needed for the present staff.

There is a place within the mental health services for the health visitor but it is necessary to examine her present tasks to decide how she will be given time to do this work. For the health visitor and for other members of the local authority staff, such as duly authorised officers and mental health workers, short intensive courses are needed.

The appointment of a psychiatric social worker is also necessary but they are in very short supply. Can they be used as tutors and advisors to the staff working in this field? asked Dr. Elliott.

The development of adequate training centres is necessary and new premises are needed where conditions will be as good as in schools. For children under 16 years the emphasis will be on social training; for those over 16 years the emphasis will be on work in the centre and occupation outside it. Transport will need consideration and the training centre might be used during holidays to give a temporary rest to parents.

For those who do not need the resources of the hospital; other accommodation, such as the half way house could be set up on an experimental basis.

We must consider how best to take people out of hospital for example, the development of social clubs is work for voluntary organisations. It would be an advantage for the psychiatrist who treats the patient in hospital, as well as the G.P., to attend there.

Residential accommodation is needed especially for older people and for those suffering from mental degeneration, as homes for the aged are not suitable and these patients do not need hospital treatment. A specific type of accommodation is needed for this group where they can be seen by the psychiatrist who will decide if therapy is necessary. This is specially important as they should be removed as soon as possible from homes for the aged. The care of the aged is a serious problem as there are many staffing difficulties.

Persons under guardianship may be placed in the care of the local authority or with approved persons. Hostels within the local authority can be used for the subnormal and the part-time appointment of a psychiatrist, who would act as an advisor, would be necessary.

The present child guidance service should be left undisturbed until it is seen how the mental health services develop.

With regard to the general practitioner and the local authority services, the emphasis is on the knowledge which the general practitioner has of the patient. The local authority, through its committees, would keep the general practitioner informed and there would be a link-up between him and the psychiatrist.

THE PART OF THE HOSPITAL

Dr. Freudenberg outlined the scope of the hospital services, saying they looked to the local authority to take an increasing share in the care of persons with mental disorders.

At the present time the value of the hospital was not estimated. The removal of the patient from the situation of tension was often the only hope of understanding and assessing the situation. Compulsory powers were only used when necessary to over-rule the patient's decision for his own welfare.

Over 60 per cent of mental disorders were admitted on an informal basis: for investigation and treatment; for resettlement; welfare institution for the handicapped; hospital-illness too severe for resettlement or if they were a danger to others.

There was, said Dr. Freudenberg, an increasing awareness of the social factors in mental illness among relatives, friends and at work, and this could help or hinder recovery. The first requirement was to accept the patient's needs, and by meeting the patients regularly, find out what he feels about life in the hospital.

The most fertile ground for improving the mental health of a group of patients is personal relationship with staff.

Now with the open ward where there are no restrictions it is more practicable to extend the unit to the general hospital, but the kind of life the patient leads in hospital is important.

Within the long stay unit there are two groups. Twenty-five per cent with mild disorders could be resettled to work within the community. For the other 75 per cent suffering from severe disorders, hospital is an alternative way of life offering rehabilitation and training.

There is a need for experimentation to consider the value of sheltered work shops and occupational centres.

CORRELATION AND CO-ORDINATION OF ALL PARTS OF THE SERVICE

Dr. MacMillan said that in co-ordinating the services, each should have an appreciation of the needs of the other, and a joint approach to the problem should be made by all bodies concerned.

Dr. MacMillan described the pattern of services which had been developed in Nottingham. Two factors determined this development: the co-operation of hospital and local authority. These services function with a common object as the patients need help from both sides.

The local health authority is responsible for the social part of the organisation and the hospital for the services needed within the hospital. This gives continuity of care for the patient as the social worker and mental welfare officer see the patient before admission and continue the care after the patient is discharged. Should this not be possible there is a proper handing over.

Co-operation with the general practitioner is also essential as he is constantly dealing with interdependent relationships in the home and a close link is needed. The danger of community care is that the patient may be subjected to too great a strain in the community and there is a great danger of him being allowed to deteriorate if left there too long.

An adequate after-care service is needed in the community where clinics should have close co-operation with the hospital, and there should be facilities for re-admission to hospital to relieve an intolerable home or community situation.

The success of any community scheme depends on a sympathetic and informed public.

Education, Experimentation and Research

A NEW APPROACH

Before discussing the need for a new approach to mental disorders **Dr. Clarke** presented a picture of the history of the care of the mentally ill. At the beginning of the nineteenth century the attitude and cruelty of the people of this country was beyond belief, and those who tried to help were derided and put to shame.

Dr. Clarke said the same resentment and attitude to the mentally ill still existed today in the general hospitals, among district nurses and among the public too. Their attitude was "this is not my problem". Illness of all kinds is our responsibility; behaviour of all kinds has to be accepted in the same way as we accept vomiting and other symptoms. Until this comes about, there will be rejection of mental patients. Dr. Clarke left us in no doubt that if faults there were, they lay in ourselves and in our attitudes, and that humane treatment for the mentally ill was our responsibility.

EXPERIMENTS IN COMMUNITY CARE

Dr. Carse described the Worthing experiment in community care of the mentally ill, saying this was nothing new or fanciful but the logical expansion of the psychiatric services.

He described the improvements which had come since the 1930 Mental Treatment Act. Better conditions within the hospitals—open doors, better diet, and better conditions for the long stay patient. The 1930 Act also brought great improvements in public relationships and public appreciation of early treatment and there was a steady and dramatic increase in admission to hospitals which was due to short term treatment.

In January, 1947 it was decided to experiment with visiting the patients in Worthing in their own homes and where possible to treat them there. Preparations were made to meet everyone concerned with the health of the

public. The headquarters of this experiment was a 20-bedded unit. A large house in a beautiful garden became the day hospital, which was staffed from the main psychiatric hospital. Most treatment given in hospitals can be given in the day hospital and visiting the homes obviated the need for long case histories. This gave the psychiatric social worker more time for case work in the day hospital, time to work with the patient at home and assist in rehabilitation. Domiciliary visits by nurses from hospital were an important part of the service.

It is impossible to build up a service like this without the co-operation of the patients, their families, the general practitioners and the public.

Out-patient treatment was stressed especially for the older patients who dislike leaving home and who can be treated there. One of the important factors of out-patient services is that the patient never loses his personality and is always a free agent. Any psychiatrist who has not personally visited patients at home, said Dr. Carse, had a lot to learn.

Dr. J. Chalmers Keddie outlined the community service for mental defectives developed in Oldham. He said circular 9/59 had been anticipated.

Oldham local health authority was fortunate in having an enthusiastic chairman who knew more about mental illness than the medical officer of health.

The hospital had been developed into a modern psychiatric unit with every facility for care and treatment and in 1950 a consultant psychiatrist was appointed by the regional hospital board and the local health authority.

Weekly meetings were arranged when staff of mental health sections attended to meet the consultant and problems of the past week were discussed. This was the beginning of the case discussion group which now meets regularly.

In Oldham community care starts soon after birth, when the health visitor visits the family at home, and this observation continues through the school health service until the child leaves school.

For handicapped children special provisions are made and even prior to the Education Act, ascertainment was good and a special school for the educationally subnormal has existed in Oldham since 1904. For the uneducable a junior training centre is provided; for the untrainable a creche where simple care is given and mothers are relieved of the care of the child for part of the day; an industrial centre for male and females has been built on the same site, where a common dining room is shared.

These centres, said Dr. Chalmers Keddie, are not gilded palaces but pre-fabricated buildings erected at a cost of £10,000. They are open all the year round from 8.30 a.m. to 4.30 p.m. and here the mental defective is trained so that he will eventually be able to hold paid employment in the community. Since the beginning of the scheme twenty trainees have been placed in employment in the community. As well as providing gainful employment for those men and women, the problems of their families are also largely solved, and the individual mental defective is in an environment where he is happy and contented and the contribution he makes to the community is part of this.

All this is achieved by co-operation and the vision of a progressive local health committee, where the hospital management committee have forged ahead passing to the local authority cases they might have kept.

SPEAKERS

D. Stafford-Clark, M.D., F.R.C.P., D.P.M., *director, York Clinic, Guy's Hospital.*

J. T. Chalmers Keddie, M.B., Ch.B., D.P.H., *medical officer of health and principal school medical officer, Oldham.*

J. Carse, M.D., D.P.M., *medical superintendent, Graylingwell Hospital, Chichester.*

P. Sainsbury, M.D., D.P.M., *director, Clinical Psychiatric Research Group, Medical Research Council: consultant psychiatrist, Graylingwell Hospital.*

Professor G. R. Hargreaves, O.B.E., M.Sc., M.R.C.P. Edin., *Nuffield professor of psychiatry, University of Leeds.*

Concluding address

THE MENTAL HEALTH TEAM PLANS FOR THE FUTURE

Professor G. R. Hargreaves said the Mental Health Act 1959 and the Royal Commission which preceded it stimulated nation wide interest such as has never before occurred. This breadth of interest owes much to the mass media of the press and much of the credit for the new legislation and the changing attitudes which made this legislation possible, must go to them.

This Act will not improve treatment but it will sweep away the legal impediments to improving all aspects of the care of the mentally ill.

The main task for the future is to ensure that the present services of the local health authority encompass mental as well as physical disorders. The effect of the last one and a half centuries can be seen in the great solidly built mental hospitals, which the Prison Commission would not welcome as a gift!

Faced with a decision about how money allocated for the improvement of the services should be spent, we must ask ourselves whether this should be used to modernise the old buildings or to build new ones? Much will depend on the needs of the local areas for there is not enough money for both. It is important to plan and formulate policy for the future which will obliterate the past and humanise the future care of the mentally ill.

The long stay mental hospital will need to be modernised, for this is the kind of work the general hospital never will or can do. The patients will tend to go to the general hospital, but here 150 years of segregation has

continued on page 234

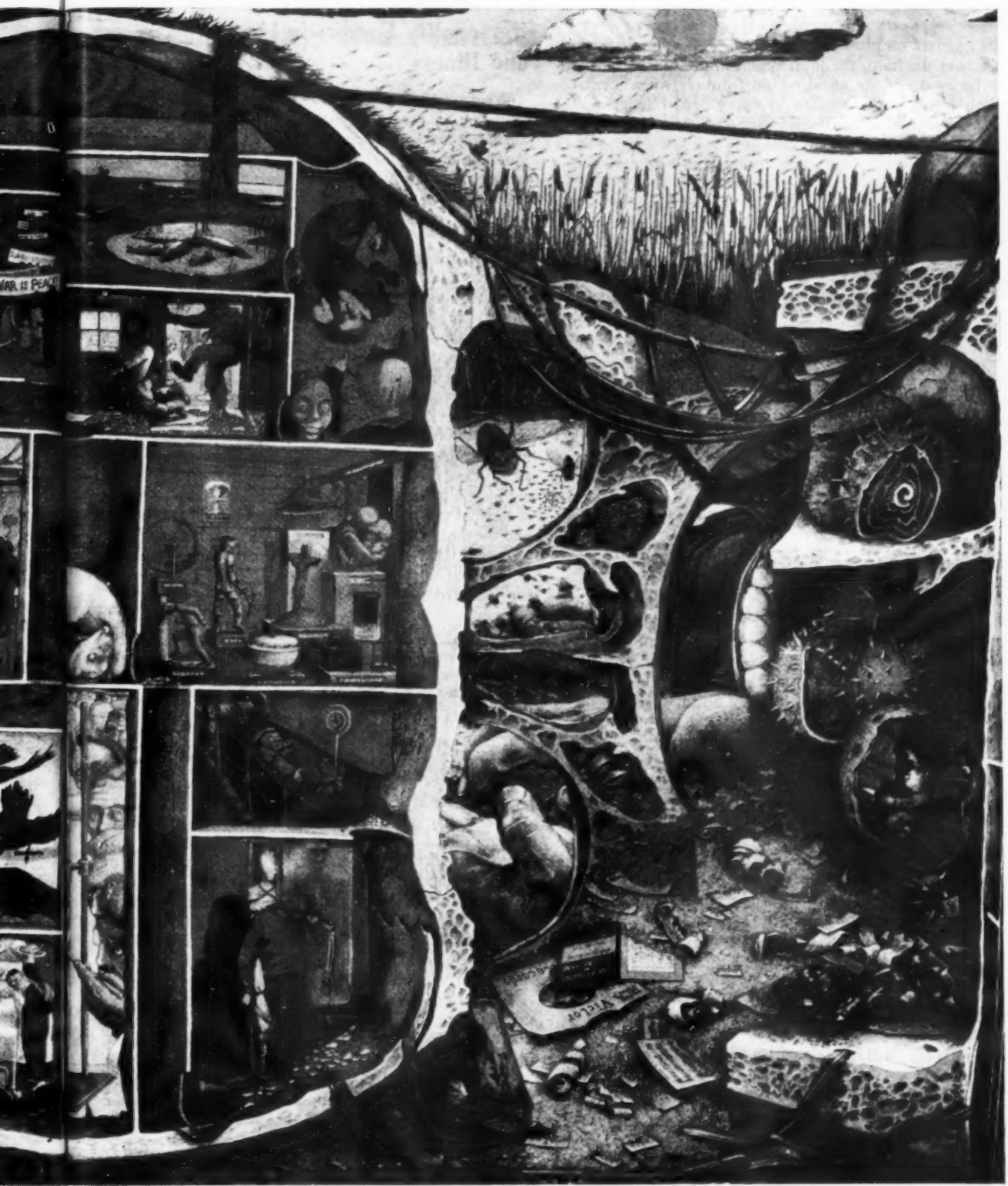
THE LABYRINTH OF A SICK MIND

FORTUNATELY, the artist who becomes ill does not lose his creative ability. This enables the progressive psychiatrist, using new techniques, to stimulate artistic talents and thereby gain deeper insight into the sick man's mind. It is not an accident that the painting reproduced here recalls the work of Hieronymus Bosch, who was obsessed with the folly and horror of this world and commented on it in nightmare terms.

The painter, a young Canadian who was familiar with Bosch's work, did it while he was a patient in a mental hospital in England. He shows himself lying on stony ground, his skull divided into the compartments of a maze from which there is no escape. Various compartments depict his miserable childhood, his sympathy for the Ukraine (his mother country), his disillusionment with political activity, his hopelessness at ever being able to share other people's faith in ideal values, his feelings of unreality and of estrangement from the sunlit "normal" world, his frustrated sexuality, his fear of imminent destruction, his impulse to cut himself to the bone to see if he has a solid skeleton like other men. The crows represent doctors viewed in a paranoid light. Below this is a fantasy of hospital treatment seen as a benevolent conspiracy. In the centre, at the bottom, he shows how it feels to be the subject of a clinical conference. The defeated rat that can find no way out is also himself.

The technique of the painting indicates that it is the work of a hyper-sensitive, obsessional patient, a prey to depressive ruminations and feelings of unreality. His technical accomplishment and intellectual powers are clearly of a high order but his severe inhibitions against expressing or even admitting positive feelings have prevented his using these talents to their fullest advantage.

By courtesy of Guttmann-Maclay Collection and World Health Organisation


WAR IS DEAD

continued from page 231

left its mark on professional thinking. As administrative practices die hard, the local health authorities will have to be aware of the ghost of old frontiers when mental disorders were the concern of many departments; and that the mental welfare officer is the residuary legatee of the relieving officer is not the fault of the new legislation. The new procedure for guardianship is to help and give protection to any type of patient who needs it. Thinking is still in terms of segregation and there is still a deep fear of mental illness which disturbs both judgement and behaviour. There is a need to get rid of those fears but this will not come about by changing the name of the hospital.

The term mental health has a legitimate use in preventive medicine, but it should not be used to replace the word psychiatry. Psychiatry is a separate branch of medicine as psychiatric nursing is a separate branch of nursing. The effect of this is that the general physician has a frugal knowledge of the work of the psychiatrist and the general nurse no practical knowledge of psychiatric nursing.

Miss Nicoll Sums Up

Looking back on the conference in an attempt to assess something of its values, I am reminded of a stone thrown into a pool of still water; the stone continues to send out ever widening circles over the pool long after it has reached the bottom.

So it seems might be the effect of the Mental Health Act 1959 and of this conference on the people of this country, for it will not only affect those who suffer from mental disorders and their families, but also all persons who in any way function within the health services.

Local health authorities, regional hospital board and hospital management committees, all other committees both voluntary and statutory whose interests lie in the health of the community and the training of personnel to maintain the services, must ask themselves if their services and the training provided are such that they will meet the total needs of the family where mental disorders occur.

This conference gave opportunity to 700 nurses, doctors, members of local health authorities, hospital management committees, and administrators from many parts of Great Britain to meet together to discuss the implications of the new legislation in the hope of developing and providing better care and understanding for the mentally ill.

It is to be hoped that each individual who had the privilege of being a member of this conference will have the same effect on the community in which he works and lives as the stone which falls into the still pool. For only if this happens will the conference have been really worth while.

Parliament has provided legislation, the Royal College of Nursing this very stimulating conference, but the future care of the mentally ill is the responsibility of all of us—as always it is *people* who matter most—people who can stop progress.

Personality Factors in Health and Illness

continued from page 226

Where, however, the mother is strict, tyrannical and domineering (and this usually goes with a henpecked husband) her son, because of the many frustrations and humiliations he suffers at her hand, grows up with mixed feelings of hostility and a deep yearning for affection As an adult he sees all women as frustrating, humiliating and denigrating and therefore can never form any close relationship or marry.

If the father is brutal and harsh, then a timid, shy, sensitive adult will develop. Where a girl finds herself involved in mixed feelings and rivalries with her parents and is unable to identify with mother, she grows up to feel it a major disaster to be a woman, feeling inferior and ashamed of her sex.

It is not possible here to go into all the emotional factors involved in personality maturation. I have mentioned, for example, nothing about the effect of insecurity on learning at school, nor have I dealt with the anxiety-ridden, frightened adult, the product of cruelty at the hands of parents.

I have indicated briefly some of the salient and perhaps somewhat extreme results of mishandling in the home, and the illness and personality disorders which can ensue, and hope I have given some idea of the importance of kindly and considerate handling of the young in the formation of adult personality.

Barrier Creams

THE support given by dermatologists to the use of barrier creams has been far beyond what is justified by the evidence, according to a leading skin specialist. Dr. F. Ray Bettley, formerly Dean of the Institute of Dermatology at the British Post-Graduate Medical Federation, London University, was delivering the Malcolm Morris Memorial Lecture on *Skin Hazards of To-day* at a meeting of the Chadwick Trust.

Dr. Bettley said that in theory the conception of a barrier cream was excellent, but to believe in a substance "so nearly bordering on the miraculous required either a naive credulity or the most conclusive scientific evidence". The latter, he alleged, did not exist.

Dr. Bettley advocated the carrying out of a thorough investigation of the use of barrier creams in industry, because he claimed that such evidence as was available was fragmentary, contradictory and inconclusive.

He said that the medical profession should demand that the experts employed by the manufacturers should publish the evidence on which their views were based in such form and detail that it could be critically assessed.

Dermatologists should also insist that the formulae of these products were made known.

Implementing the Mental Health Act

The Minister of Health has sent to hospital boards a memorandum on the informal admission of patients to mental hospitals.

THE provisions of the Mental Health Act 1959 are to come into operation on such dates as the Minister may by order appoint. Different dates will be appointed for different purposes of the Act.

It will be some months before the Minister is able to bring into force the provisions of the Act relating to patients who are subject to detention while in hospital.

The Minister has made an order concerning admission to hospital which took effect from October 6th, 1959. Any designated mental hospital, registered hospital or licensed house and any other hospital may admit mentally ill patients without using the procedures laid down in the Lunacy and Mental Treatment Acts.

This order does not repeal any of the provisions of the Lunacy and Mental Treatment Acts relating to voluntary, temporary or certified patients. These remain in force until an order is made effecting the repeal of the relevant parts of these acts and bringing the provisions of parts IV and V of the new Act into force.

For the present, therefore, the provisions of the Mental Treatment Act, 1930, for the admission of voluntary patients remain in force side by side with the new power to admit patients informally.

Review of present patients

Medical superintendents of designated mental hospitals should be asked to undertake a review of present patients, whether voluntary, temporary or certified, and to consider which patients can suitably remain in hospital on an informal basis.

Any patients considered suitable to remain informally may be discharged from the present authority for detention by using any of the procedures for discharge under the Lunacy and Mental Treatment Acts and Mental Treatment Rules. Notices of discharge should be sent as required under Rule 64 of the Mental Treatment Rules, 1948, but a note should show that the patient is remaining in hospital on an informal basis.

Hospital Records, Notification of Admission, etc.

The Minister is advised that the Mental Treatment Rules, 1948, do not apply to patients admitted informally or remaining in hospital informally.

When such patients leave hospital, it should be standard practice to notify the general practitioner who will be providing general medical services for the patient after discharge and, in suitable cases and with the patient's consent, the local health authority. The general practitioner and the local health authority should also, where appropriate, be consulted beforehand about the arrangements for the patient's after-care. No notification of admission or discharge need be made to the board of control or Ministry of Health.

NEW YEAR HONOURS

Our congratulations go to the following:

Mrs. Barbara Brooke—D.B.E. for political services.

Mrs. Brooke will be well-known to many of our readers for her services to district nursing. She has been a member of the council of the Queen's Institute since 1935 (with a break in 1944/45) and holds its twenty-one years' administrative service badge. Mrs. Brooke has served on a number of committees and sub-committees, including the general executive (of which she is at present vice-chairman), local health services executive, affiliation, midwifery, nursing, reconstruction, administration, parliamentary and negotiating, and training (of which she was chairman for six years).

Mrs. Brooke is a member of the Hampstead Borough Council. Housing, education, and hospitals are her special interests, and these are borne out by some of the appointments she holds: member of the north-west metropolitan regional hospital board and of the council of Westfield College; governor of Godolphin and Latymer School; chairman of Hampstead Tuberculosis Care Committee; and president of the St. John's Nursing Division in Hampstead. Since November 1954 she has been a vice-chairman of the Conservative party.

Mrs. H. Christmas—M.B.E., lately supervisor of midwives and home nurses, Glamorgan County Council (Aberdare and Mountain Ash Division).

Miss S. Hughes—M.B.E., district superintendent, Ranyard Nurses, London.

Miss B. M. Langton—M.B.E., superintendent health visitor, Salford County Borough.

Gratitude

Extract from a letter to the general secretary of the Institute from a retired Queen's nurse who is an annuitant of the long service fund:

I do want to thank the members of the Queen's Institute for all their goodness and kindness to me for so long and I am wondering if I ought to go on receiving as I shall be ninety-seven years of age next year and as I have such perfect health I am likely to live much longer.

My only drawback is my injured leg and I am able to walk about in the house and the garden but if I go for a short walk outside I always take a stick.

Mary E. Wilkinson

Changing your job? What about your SUPERANNUATION?

A NEW leaflet on superannuation has just been issued for the benefit of nurses, midwives and medical ancillaries leaving the service of a local authority. It gives brief information on the alternatives available when changing employment. It is for general guidance and is not intended to be a comprehensive statement of the provisions of the superannuation acts, regulations and rules. Anyone in doubt as to what to do should consult the superannuation office of her authority.

As regards any of the alternatives in which the F.S.S.N. is mentioned in these notes nurses are advised to consult the Scheme which will give information appropriate to particular circumstances, without charge, to members and non-members on application to the Federation Superannuation Scheme for Nurses and Hospital Officers, Rosehill, Park Road, Banstead, Surrey.

The main points in the leaflet are:

1. Transfer to another Local Authority

If you have been a contributory employee under one local authority, and within twelve months of leaving that employment become a contributory employee under another local authority a transfer value is payable by the administering authority and superannuation rights are transferred to the new employment. If however there is an interval between these two employments during which you have been a participant in F.S.S.N., you should refer to the Scheme.

2. Transfer to the National Health Service

Similar provisions to those in paragraph 1 apply under interchange rules, if you make the necessary application to your new employer within three months of taking up your new employment.

3. F.S.S.N. members transferring to another local authority or to the National Health Service

If you are a member of the F.S.S.N. and your present authority has agreed to make the employer contributions under that Scheme on your behalf, you may apply to your new authority or to the N.H.S. to continue in the F.S.S.N. The necessary application form may be obtained from the F.S.S.N.

4. Transfer to certain other employments

Similar provisions (to those in paragraph 1) for transfer of superannuation rights apply under interchange rules to certain other employments (e.g. electricity and gas boards). You should apply to your new employer; there is a time limit for your application.

If, however, you are a member of the F.S.S.N. alternative arrangements may apply.

5. Transfer to any other employments

If you enter employment (including employment in certain nationalised industries, or in private practice) outside the services referred to in paragraphs 1, 2 and 4 you can, providing you become a member of the F.S.S.N. apply to your present employing authority to pay a sum to F.S.S.N. which will purchase a policy of insurance on your life to provide an annuity for you on retirement (or death benefits in the event of your premature death). The amount payable to the Scheme will normally be the same as the transfer value which would otherwise have been payable (paragraph 1).

To comply with the above rules there are two requirements. The first is that within twelve months of ceasing to be a contributory employee you must enter service eligible under F.S.S.N. and commence or resume F.S.S.N. contributions. The second is that your application must be lodged within three months of commencing or resuming contributions under F.S.S.N. in respect of such service.

An explanatory leaflet and application form is obtainable from the F.S.S.N.

6. Overseas employments

(a) Provided you become a member of F.S.S.N., the procedure in paragraph 5 can be adopted.

(b) Alternatively, in the case of *certain* overseas employments you can apply to your local authority to have your benefits preserved in "cold storage". This method involves observance of conditions laid down in the rules. If you return to Local Authority service in this country within twelve months of leaving that overseas employment, the rules enable you to reckon your previous local government service in your new employment.

7. Re-entry to local authority service

(a) If you have been granted a payment to the F.S.S.N., as referred to in paragraphs 5 and 6(a) and subsequently re-enter local authority service within five years of leaving it, you can apply for a sum equal to that payment to be paid over to your new local authority provided that you have been a participant in F.S.S.N. within the twelve months preceding such re-entry. In that case your past local authority service again becomes reckonable under local government superannuation.

(b) Alternatively, you can choose to leave the payment with the F.S.S.N.

You may also, if you wish, apply to the new authority to continue to make employer contributions under the F.S.S.N. on your behalf.

8. Return of contributions

(a) It may be tempting to obtain a refund but you should consider the above carefully before making application and obtain information from your superannuation office or the F.S.S.N.

(b) If your contributions have been refunded and subsequently you enter an appropriate employment, then none of the paragraphs 2, 4, 5 and 6 can apply unless you repay the amount refunded together with any sum which was deducted for income tax when the refund was made.

(c) A reduced transfer value would be paid under paragraph 1 if your contributions had been refunded and you did not repay them. Your previous service would then only reckon as non-contributing for pension purposes, i.e. in effect, at half-rate.

(d) No return of contributions can be made by a local authority if paragraphs 1, 2, 4, 5 and 6 apply.

9. Service

(a) You should notify your new employer immediately of your previous employment and show him all previous notifications of service issued to you.

(b) If you are, or are considering becoming, a member of the F.S.S.N. you should notify that Scheme of your new appointment.

(c) Under either (a) or (b) it is important to supply full and accurate information.

The leaflet is issued by the Federated Superannuation Scheme for Nurses and Hospital Officers, with the concurrence of the County Councils Association and the Association of Municipal Corporations. The latter are commending it to their local health authority members, to whom the F.S.S.N. is supplying leaflets.

Queen's Nurses Personnel Changes

APPOINTMENTS

Superintendents

Anders, L. A., St. Helen's, Asst. Supt.—Appleby, A. M., Oxon., Asst. Supt.—Bonnett, E. K., Cambs., Dep. C.N.O.—Borchard, A. M., Bucks., Dep. Supt.

Nurses

Barrow, H. J., Bournemouth—Birt, E. A., Salop—Bond, P., Metropolitan—Boote, Mrs. A. H., Cheltenham—Boyne, Mrs. J. E., W. Sussex—Cannell, E. M. I., Surrey—Clarke, E., Westmorland—Cross, M. H., Herts.—Coughlan, S. J., Worcs.—Douglas, M., Oxon.—Gwilliam, R. M., Shropshire—Lewis, A. T., Surrey—Mulligan E. K., Liverpool—Needham, Mrs. P., Surrey—O'Flynn, M. I., Liverpool—Ormerod, E. M., Lancs.—Russell, S. M., W. Sussex—Traw, K., W. Sussex—Walker, R., E. Sussex—Wheeldon, M. L., N. Riding.

LEAVE OF ABSENCE

Burkett, B. E., Domestic reasons—Carbery, M., H.V. trg.—Chase, D. M., H.V. trg.—Messenger, L., Domestic reasons—Milbank, D. J., H.V. trg.

REJOINERS

Collard, Mrs. G. C., Somerset—Curtis, Mrs. I. M., Cornwall—Fletcher, Mrs. M., Berks.—Floom, Mrs. B. M., Brixton—Griffiths, Mrs. C. M., Cardiff—Jones, L. E., Southport—Jones, Mrs. S., Denbighs.—Kneale, F. M., Lancs.—McKain, Mrs. K., Lancs.—Nash, G. M., Bristol—Potter, Mrs. I. M., W. Riding.

RESIGNATIONS

Alcee, A. N. N., Kilburn & W. Hampstead, Return to W. Indies—Bennett, M. E., Cardiff, Domestic—Biart, C. M., Isle of Ely, For missionary work—Brand, Mr. P., Camberwell, Hosp. post—Buttimore, A. A., Somerset, Midwife tutor's course—Edward, Mrs. L. H., Warcs., Going to Australia—Florain, A. A. J., Herefords., Marriage—Glossop, K. W., W. Riding, Marriage—Harris, Mrs. D. M., Plymouth, Hosp. post—Hatton, Mrs. M. A., Isle of Ely, Ill health—Hoban, S., Manchester, Marriage—Jones, E., Mont., Personal—Kennedy, J. A., Nottingham, Domestic—Lacey, W. E., Somerset, Retirement—Lawrence, G. J. L., Radnors., Domestic—Lefley, E. H., Herts., Retirement—Mackenzie, B., Surrey, Personal—McLean, R. W., Leytonstone, Going to Canada—Meneaud, Mrs. B. D., Herefords., Marriage—Nield, Mrs. P. S., Birmingham, Domestic—Orpin, V., Kent, Ill health—Patten, M. J., Cardiff, Hosp. post—Paxton, Mrs. M., Bradford, Domestic—Pittendreigh, M., Brixton, H.V. post in Scotland—Pruett, Mrs. D. E., Bristol, Retirement—Ramshaw, E. M., Norfolk, Retirement—Seymour, M., Sunderland, Retirement—Shaw, J., Surrey, Going to Tasmania—Sinn, F. J., Southend-on-Sea, Post in Canada—Thompson, D. M., Cheshire, Other work—Venes, Mrs. B. M., Camberwell, Personal—Walker, M., Rotherham, Marriage—Wilkinson, J. D., Kent, Retirement—Wilson, F., Surrey, Personal—Windle, H., W. Riding, Domestic—Young, Mrs. M., Blackburn, Domestic.

SCOTTISH BRANCH

APPOINTMENTS

Superintendents, etc.

Ferrier, M. J., Glasgow (Bath Street), Sen. Asst. Supt.

Nurses

Boa, C., Strontian—Fraser, F. G., Biggar—Hunter, E. L., Methil—MacLeod, F. M. R., Foyers—Murray, A. M., Kilsyth—Paterson, V., Longside—Ramage, J., Bothwellhaugh.

RESIGNATIONS

Fleming, E., Tullibody, Marriage—MacDonald, M. A., Bower, Retired—Ogilvie, C., Dundee, Retired—O'Kane, A. L., Kilchoan, Other work—Robertson, M. A., Dunoon, Retired—Smith, M. McLean, Bridge of Allan, Retired—Urquhart, M., Longside, Home reasons.

ISLE OF WIGHT NURSING OFFICER RETIRES

MISS Emily H. Moss, who retired from her post as deputy superintendent and non-medical supervisor of midwives in the Isle of Wight on 31st December 1959, has devoted 45 years to the nursing profession.

Miss Moss received her general training at St. Mary Abbots hospital and Queen's training at Camberwell and subsequently worked at Oldbury and Watford. She was appointed assistant superintendent at St. Olave's D.N.A. in 1934 and first joined the staff of the District Nursing Association at Ryde in 1938 as superintendent. Later she was also appointed non-medical supervisor of midwives.

In 1956 Miss Moss took up her Isle of Wight post.

POST GRADUATE COURSE FOR WEST SUSSEX

PUBLIC health nurses employed by West Sussex County Council will be attending their annual post graduate course at Lodge Hill, near Pulborough, at the end of the month.

The lecture programme includes Factors contributing to Emotional Stress in Children by Dr. Mary Capes and Miss I. G. Beatty; Disseminated Sclerosis, with particular reference to home management, by Dr. J. D. Whiteside; and Recent Developments in the Care of the Newly Born by Dr. Simon Yudkin. The Wednesday afternoon will be taken up with visits to Worthing Occupation Centre, C.I.B.A. Laboratories, LEC Refrigeration, and the School and Hospital for the Physically Handicapped, Chailey Heritage.

NURSES' ELECTION TIME

DURING the next few weeks nurses will be electing their representatives to serve on the council of the Royal College of Nursing and on the General Nursing Council. Every College member is entitled to vote in the College election, and every registered nurse in the G.N.C. election.

It is of vital importance to the future of the service that public health nurses should be adequately represented on both these national bodies, which to a great extent control nursing in this country. In order to achieve this, every public health nurse must cast her vote. Each vote wasted lessens the chance of public health representation. Even one vote can make a difference.

No public health nurse has the excuse of not knowing any of the candidates. Several well-known public health nurses are standing for the College election: Miss L. Joan Gray, general superintendent, Q.I.D.N.; Mrs. A. A. Woodman, the present chairman; Miss J. M. Young, county nursing officer, Pembrokeshire; Miss P. C. L. Gould, county superintendent health visitor, Lancashire; Miss I. H. Sinnett, retired superintendent of health visitors; and Miss J. R. Hurry, county nursing superintendent, Fife. (The list of candidates for the G.N.C. is not available at time of going to press.)

The election for the council of the Royal College of Nursing is an annual event as one-third of the members retire each year. There are seven geographical divisions and a certain number of seats on the council are allocated to each. Irrespective of where she lives or works, a college member may vote for any candidate. The candidates with the highest number of votes in each division are elected to represent that division.

The General Nursing Council consists of twelve people appointed by the minister of health, three appointed by the minister of education, two appointed by the Privy Council, and seventeen elected by registered nurses. Fourteen of the latter are general nurses (one from each area), two are mental nurses (one male and one female), and one is a sick children's nurse. It is these seventeen who are now to be elected, to serve for the next five-year period.

Readers are urged to fill in and return their ballot papers promptly.

THE SHEET THAT MOVED

THE West country is renowned for its superstitions, its witches and piskies. Stories of strange happenings are sometimes told around the fireside and in the bar at night, and strangers might well think the stories far fetched at times. Be that as it may, this story is true. It concerns a busy West country hospital.

I was on night duty in one of the male medical wards and one evening on reporting to sister for duty, was told that a new patient suffering from kidney failure had been admitted to the ward during the day. The patient was a young gypsy aged, so far as I remember, about 17 years. His people had brought him in by caravan and had signed the admission form with an X as none of them could read or write.

The boy was placed in a bed mid-way down the ward, and very soon I went to see him to ask if he was comfortable and if he needed anything. He was dark and good looking with large black mournful eyes which appeared to stare without blinking. He was very shy and would not talk. I tried at various times during the succeeding nights, but he would only nod his head. He watched me with his unblinking stare wherever I went in the ward; I became very conscious of his eyes, they were so brilliant, almost mesmeric. I noticed that he answered the "up" patients, but he never volunteered a remark.

It must have been a severe ordeal for the boy who, presumably had never known existence outside a caravan life, to be suddenly put into such close proximity with people not of his own kind. I think we all appreciated this and everyone tried to be kind to him.

One night I went on duty to find his condition had deteriorated and he had Cheyne Stokes breathing. The patients near him were all aware that he was fighting a losing battle; the difficult breathing proclaimed it to all. Yet, when I went to him, his eyes remained open, staring into space, and continued so up to the time of his death in the early hours of that morning.

Night sister confirmed his death and told me she would send the night runner to assist with the last office, as was the custom in the hospital. The night runner however, was occupied with a patient who was being prepared for an emergency operation and I knew her arrival would be delayed. I therefore prepared to wait for her, having first closed the dark eyes, straightened the body and covered it with a sheet.

I filled in the time at sister's desk. I remember I began to work at the making of a splint, when suddenly I sensed rather than heard, a movement behind the screens, then another movement.

At first I was too frightened to move. However, I stood up and went to peep through the screens telling myself there could be no movement from a dead body. But there had been movement. The sheet which I had placed over him was drawn down to his waist and his eyes were open, seeming once more to be looking at me. There is no explanation of how the sheet moved. There was no window behind the bed, no door beside him, no draught anywhere; and there was no doubt the boy was dead.

Soon after this the night runner put in a hurried appearance telling me she couldn't stay long, so we rapidly did what was necessary. I telephoned the porters asking for the body to be moved to the mortuary situated in the hospital grounds. They answered they were waiting to take the theatre case back to the ward, but would come as soon as possible.

The wait seemed endless. I was still somewhat shaken although my commonsense told me there must be an explanation for the incident, but to this day I have never found it. I went off duty at 8.0 a.m. very glad the night was behind me.

But the strange happenings had not yet finished. Later that morning, many gypsy caravans were seen making a steady trek towards the hospital. They lined up one behind the other in the road outside the hospital with tired horses who had travelled long distances, starting out before dawn if all accounts were to be believed; horses waiting patiently while the gypsies made their pilgrimage to the mortuary.

By what means did these people know of the boy's death? There had been no enquiry at the hospital for him since his admission. Yet by some remarkable and perfect timing, the gypsies had come together from widely scattered areas, from the hills and the valley, to pay their respects to the boy who had died a lonely death in a strange place.

H. E. Basterfield, S.R.N., S.C.M., M.T.D., Q.N. & H.V. certs.

NURSING BOOKSHELF

Aids to Tropical Nursing, by **Dorothy E. Cocker, S.R.N., S.C.M., Sister Tutor Cert.** Ballière, Tindall and Cox, price 9*s* 6*d*.

AIDS to Tropical Nursing, first published in 1944, is a well known textbook for those working in tropical countries. There must be many nurses posted abroad, perhaps for the first time, who are thankful to have with them a copy of this small, easily packed book which contains so much valuable information on the diagnosis, treatment and nursing care of tropical diseases.

The fourth edition, recently published, is of special interest to the public health nurse. It has been planned not only to meet the needs of the nurse working in hospital, but also those of all health nurses and auxiliary medical personnel who work in remote villages without a doctor near at hand. These people have not only to diagnose and treat many diseases without medical help, but also have the duty of teaching the principles of health and hygiene to the community.

In the new edition, which has been completely revised and brought up to date, the latest treatments and drugs have been included, while throughout the book the prevention of many tropical diseases is stressed.

The opening chapter deals with the promotion of health in the tropics and sets out the duties of the nurse as health teacher. The section on nutritional anaemias and diseases, which has been enlarged and contains a description of kwashiorkor will be of particular interest to the rural health worker in areas where malnutrition is common. An entirely new section on venereal diseases has been added, which will be helpful to those who are frequently called upon to treat these conditions in remote districts.

Other sections deal with a variety of subjects including infections due to contaminated food and water, parasitic infestation (giving the latest treatments for worms of all kinds), malaria and skin diseases.

The additional illustrations and photographs of patients suffering from yaws, kwashiorkor and leprosy will be valuable to those who have not had previous experience of such diseases.

All those concerned with medical and nursing work overseas will welcome the new edition of this most useful book.

I.D.I.

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Displayed Setting: 17s. 6d. per single column inch. Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.)

ISLE OF ELY C.N.A.
(Affiliated with Q.I.D.N.)

District Nurse/Midwives required for:
Chatteris—Two vacancies.
Littleport—One or two required, H.V. Cert. desirable.
Manea—One vacancy. H.V. Cert. desirable not essential.
Whittlesey—Two vacancies (immediate).

Accommodation available. Financial assistance towards removal expenses. Motorist or willing to learn. Application form and further information can be obtained from Superintendent Nursing Officer, County Hall, March, Cambs.

CUMBERLAND COUNTY COUNCIL
(Affiliated to the Queen's Institute of District Nursing)

Health Visitors
(a) **Workington**—Two required.
(b) **Whitehaven**—One required. Combined duties.
(c) **Cleator Moor**—One required. Combined duties.
(d) **Penrith**—Two required. Unfurnished flat available over new clinic. Would suit friends.

District Nurse/Midwife/Health Visitors for Rural Areas
(a) **Bootle** (near Millom).
(b) **Bassenthwaite** (Lake District).

House available in each case furnished or unfurnished.
(c) **Dearham**—New house available.

Cars will be provided for all the above appointments.

Queen's District Training—Applications are invited from Nurses S.R.N., S.C.M., wishing to work as district nurse midwives in Cumberland. Arrangements can be made for them to take four months' training at an approved Queen's Nurses' Training Home.

Health Visitors' Training—Scholarships value £420, plus travelling allowances, are available for Nurses S.R.N., S.C.M., wishing to take a nine months course at an approved training college in preparation for the health visitor's examination of the Royal Society of Health, and subsequently to work in Cumberland for a miminum period of two years.

Applications for the combined course for district and health visitor's training also considered.

Application forms obtainable from the County Medical Officer, 11 Portland Square, Carlisle.

DORSET COUNTY COUNCIL
Deputy Area Nursing Officer (Poole Borough)

Applications are invited from suitably qualified Queen's Nurses for the post of Deputy Area Nursing Officer. Preference will be given to applicants having sufficient experience to qualify for supervision of health visiting, midwifery and home nursing. Motorist essential. Whitley Council salary scale £750×£30—£870. Forms and further particulars from the Clerk, County Hall, Dorchester, to be returned by 20th February.

MIDDLESEX COUNTY COUNCIL

Deputy Matron (Res.) reqd. initially at Red Gables Mother and Baby Home, Hornsey. Hostel for 16 unsupported mothers and their babies. Must be S.C.M. and ONE of the following—S.R.N., S.E.A.N., R.S.C.N., C.N.N. Salary £655—830 less £205 p.a. for board and lodging. Established, prescribed conditions. Particulars and two referees to County Medical Officer, Ref. 'S', 3, 5 and 7 Old Queen Street, S.W.1, by 15th February. (Quote B.741D.N.J.)

NORFOLK COUNTY COUNCIL

Applications are invited for vacancies in the undermentioned areas:—

District Nurse/Midwife/Health Visitor (preferably with Queen's and H.V. Certificate or willing to train).
Great Melton. Unfurnished house
Fincham. Unfurnished house later.
Hethersett. House being built.
Hockham, nr. Thetford. Unfurnished house.
Long Stratton, South Norfolk. Second nurse, living separately. Furnished Accommodation.
Neatishead. Unfurnished house.
Tacolneston. Unfurnished house.

District Nurse/Midwife (S.R.N., S.C.M., and preferably with Queen's Certificate).
Ashill. Unfurnished house.
Fakenham. Increase of staff. One of three nurses living separately. Unfurnished house.
Wymondham. Double district. Unfurnished house.

Part-time relief duties
Dereham
Norwich Fringe area
Wymondham
Thetford

Full-time Midwife (S.R.N., S.C.M., and preferably with Queen's Certificate).
King's Lynn. Two vacancies. Unfurnished house and unfurnished flat.

Full-time General Nurse
Dereham. Furnished accommodation.

Full-time Midwife or District Nurse/Midwife willing to do combined duties.
Watton. Furnished accommodation—house being built.

Facilities available for Health Visitor and Queen's Nurse training with a view to generalised duties.

Staff needed for relief duties—holidays or longer periods.

Whitley Council salaries and conditions of service.

Successful applicants can use their own cars (loans available for purchase) or cars can be provided. Consideration will also be given to supplying furniture if required.

Application forms from County Medical Officer, 29 Thorpe Road, Norwich, Norfolk, NOR OIT.

SOMERSET COUNTY COUNCIL
(Midwifery and Nursing Services)

Taunton—S.R.N., S.C.M. or S.R.N. preferably with district training. Resident in comfortable nurses' home or non-resident.
Yeovil—S.R.N., S.C.M. required, preferably with district training. Comfortable nurses' home, resident or non-resident.
Peasedown St. John (near Bath)—Two Queen's Nurse/Midwives/Health Visitors required. Two cars provided. Small fully furnished house.
Batheaston (adjoining Bath)—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district in group of four nurses. Car provided. House available, furnished or unfurnished.
Chilcompton—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district. Car provided. Lodgings, house to be built.
Bleadon (adjoining Weston-super-Mare)—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district. Car provided. Accommodation available.
High Littleton—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district in group of nurses. Car provided. Small furnished flat available.
Wookey (near Wells)—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Furnished bungalow available. Motorist.
Nether Stowey—Queen's Nurse/Midwife with Health Visitors certificate or willing to train. Generalised duties on single district in group of nurses. Car provided. Furnished flat available.
Bridgwater—S.R.N., S.C.M., or S.R.N. preferably with district training. Resident in nurses' home or non-resident. Car available.

Financial help given with driving tuition.

For further particulars apply to: County Medical Officer of Health, County Hall, Taunton.

HOLIDAY CAMPS FOR DIABETIC CHILDREN
Nursing Staff Required

The British Diabetic Association arranges summer holiday camps for diabetic children every year during the month of August. Each camp lasts for a fortnight and provides excellent experience in the management of diabetes and the care of children.

The Association would be glad to hear from nurses who would be willing to help at the following camps: Dorton House, nr. Aylesbury, 17th–31st August, and Castlecraig School, Peebleshire, 3rd–17th August. All expenses will be met and an honorarium of £7 per week is paid to nursing staff.

Please apply to the Secretary-General, British Diabetic Association, 152 Harley Street, London, W1, stating qualifications and experience.

Other Advertisements on p. 244

HEREFORD COUNTY COUNCIL

Applications are invited for the following appointments:—

Hereford City

Health Visitor for full-time Health Visitor/School Nurse duties.

District Nurse/Midwife for combined duties.

Accommodation available. Cyclist or motorist—car provided.

Application forms and terms of appointment may be obtained from the County Medical Officer, 35 Bridge Street, Hereford.

EXETER—DEVON
(Training Home)

Assistant Superintendent required (resident); Health Visitor's Certificate preferred. Interested in practical teaching and in general administration. Previous experience not essential. Motorist—car provided or allowance to car owner.

Apply, Superintendent, Exeter Maternity and D.N.A., 11, Elmgrove Road, Exeter.

DORSET COUNTY COUNCIL
(Member of Queen's Institute)

Applications are invited from **district nurse/midwives** for single area post in North Dorset comprising Mappowder and surrounding rural area. Unfurnished house available. Whitley salary and service conditions. Motorist essential. Car provided or allowance paid. Application forms from the Clerk, County Hall, Dorchester to be returned by 20th February.

JESUS HOSPITAL, BRAY, BERKS.
Vacancy for Resident Nurse-Matron from 27th March to take charge of small Sick Bay and look after elderly inmates of these modernised 17th century almshouses which are situated in a pleasant village 1½ miles from Maidenhead. The Hospital is supervised by a resident Chaplain.

Applicant need not be fully trained, but must be patient and understanding with old people. House, lighting and coal free, plus small salary.

Further particulars may be obtained from the Rev. P. B. Thorburn, Chaplain's House, Jesus Hospital, .but applications for the post should be sent to: The Clerk, Fishmongers' Company, Fishmongers' Hall, London Bridge, E.C.4.

COUNTY BOROUGH OF SOUTHEND-ON-SEA
Student Health Visitors

Tuition grant and salary during training. One year's post-certificate engagement (Whitley Council salary). Applications invited for appointment in April next. Applicants must be S.R.N. and C.M.B. (Part I). Further particulars and forms of application from the Medical Officer of Health, Warrior Square, Southend-on-Sea.

ARCHIBALD GLEN, Town Clerk

QUEEN'S INSTITUTE
Health Visitor Courses, 1960–1961

1. Health Visitor Course

Nine months course to prepare students for the Health Visitors' Examination of the Royal Society of Health.

2. Health Visitor/District Nurse Course

One year's course to prepare students for:

(a) Health Visitors' Examination; and

(b) Queen's Roll Examination in District Nursing.

Further information and details of bursaries from Education Dept., Q.I.D.N., 57, Lower Belgrave Street, London, S.W.1.

QUEEN'S INSTITUTE OF DISTRICT NURSING

Bursaries for Public Health Tutor Courses
Two bursaries of £400 each are being offered by the Queen's Institute to enable Queen's Nurses to take one of the following courses at the Royal College of Nursing, beginning in September 1960.

(a) **District Nurse Tutor Course.**
(b) **Health Visitor Tutor Course.**

Applicants must hold the Health Visitor's Certificate and have had wide experience in district nursing, including generalised service or full time health visiting.

Further information may be obtained from the Education Department, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

CORPORATION OF THE CITY OF ABERDEEN
Health Visitor Training Course

A course of training (of approximately nine months' duration) for the Health Visitor's Certificate will commence in September, 1960.

Applications for enrolment are now invited from State Registered General Trained Nurses holding qualifications in midwifery.

1. Applications for places as students assisted by Aberdeen Corporation:—

Each Assisted Student, who will be under contract to work as a Health Visitor in Aberdeen for one year after qualifying, will receive a maintenance allowance of £7 10*s* weekly throughout the period of the Course and will have her examination fee and her railway fare to the examination centre paid by the Corporation.

2. Applications for students not so assisted:—

There are a number of places available for students seeking to take the course at their own expense or assisted by other Local Authorities.

The fee for the Course, payable by all students, is £10 10*s*.

Forms of application for "assisted" and "non-assisted" places may be obtained from the Medical Officer of Health, Willowbank House, Willowbank Road, Aberdeen, and should be returned to him within four weeks of the appearance of this advertisement.

Town House, Aberdeen — J. C. RENNIE, Town Clerk

A holiday for two or three weeks is offered at Champney House, Pembury Road, Tunbridge Wells, by John E. Champney's Trust. The Home is endowed by the Trust so that the charge is reduced to 4½ guineas a week. Teachers, Nurses, Ministers of Religion, Social Workers and other persons in active life, especially younger people, are invited to apply for particulars to the Warden at the above address.

DIRECTORY OF DISTRICT NURSING AND STREETS LIST FOR LONDON

Handy reference to streets and blocks of flats in the County, to Boroughs, the appropriate district nursing association and other social services. 3*s* 6*d* post free from the Central Council for District Nursing in London, 25 Cockspur Street, London, S.W.1.

THE GLASGOW DISTRICT NURSING ASSOCIATION
Affiliated with the Queen's Institute of District Nursing Scottish Branch

Applications are invited from experienced **Queen's Nursing Sisters** willing to take the Course commencing September, 1960, for the District Nurse Tutor's Certificate, and subsequently teach with the above Association. Applicants should be State Certified Midwives and hold the Health Visitor's Certificate. Applications not later than 29th February.

Further particulars may be obtained from the Senior Superintendent, Glasgow District Nursing Association, Room 32, 40 Cochrane Street, Glasgow, C.1.

SOMERSET COUNTY COUNCIL
Health Visitors' Scholarships

The **Somerset County Council** offer scholarships at approved training schools in preparation for the **Health Visitors' examination** of the Royal Society for the Promotion of Health. Candidates must be S.R.N., S.C.M.

Tuition fees and first examination fees are paid by the County Council. During training students receive an allowance at the rate of three-quarters of the minimum salary of a qualified health visitor.

Full particulars and application forms can be obtained from The County Medical Officer of Health, County Hall, Tau 'on.

QUEEN'S NURSES' BENEVOLENT FUND
Founded in 1913 *by Queen's Nurses, for Queen's Nurses*

Minimum subscription FIVE SHILLINGS a year.

OBJECT—To assist financially colleagues who have to give up work owing to illness.

APPLICATIONS for financial assistance may be made for a GRANT, after three consecutive subscriptions previous to going off duty owing to an illness of short duration have been paid, and after salary rights have been exhausted. *OR*

AN ANNUITY, after five consecutive subscriptions have been paid up to time of going off duty, when the illness involves resignation from District Nursing, and the applicant is unable to undertake other work.

SUBSCRIPTIONS should be sent to Miss Ivett, St. Anthony's, Marine Hill, Clevedon, Somerset from whom further details can be obtained.

An Annual Report, with a renewal notice, is posted direct to all subscribers each year.

Nurses visiting London are cordially invited to stay at Florence Nightingale House. Terms for Visitors: Weekly (Bed, Breakfast and Dinner and Full Board at Weekends) £6 6 0, Bed and Breakfast (up to 4 days) £1 1 0, Dinner 6*s* 0*d*; Student Nurses: Weekly £5 5 0, Bed and Breakfast (up to 4 days) 17*s* 0*d*, Dinner 5*s* 0*d*; August (Student Nurses) Weekly £6 6 0, Other visitors weekly £7 7 0. Apply to theWarden, Florence Nightingale House, 173 Cromwell Road, London, S.W.5, Telephone Freemantle 6456, Students' No. Freemantle 6457. Nearest Underground station, Earl's Court.